DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03 - 18**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2003**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY 2004 $ 0
b. FFY 2005 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:
This amendment eliminates the use of the proxy methodology from the Texas Medicaid Disproportionate Share Hospital Program. The state had allowed hospitals, which were unable to calculate their uninsured charges for inpatients and outpatients, to receive a proxy calculation. The elimination of the proxy methodology requires hospitals to calculate their uninsured charges for inpatients and outpatients.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jason Cooke by Robert Rowe

13. TYPED NAME:
Jason Cooke

14. TITLE:
State Medicaid/CHIP Director

15. DATE SUBMITTED:
September 23, 2003

16. RETURN TO:
Jason Cooke
State Medicaid/CHIP Director
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 23 2003

18. DATE APPROVED: APR - 5 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA – 179 (07-92)

(12) Cost-to-charge ratio (inpatient only) is the hospital's overall inpatient cost-to-charge ratio, as determined from its Medicaid cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicaid cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.
(13) Cost-to-charge ratio (inpatient and outpatient) is the hospital's overall cost-to-charge ratio, as determined from its Medicaid cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicaid cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.
(14) Gross inpatient revenue is the amount of gross inpatient revenue (charges) reported by the hospital in the appropriate part of the Medicaid cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicaid cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.
(15) Adjusted hospital specific limit is a hospital specific limit trended forward to account for the inflation update factor since the base year.
(16) Bad debt charges are uncollectable inpatient and outpatient charges that result from the extension of credit.
(17) Inflation update factor is a general increase in prices as determined by the state. For additional information concerning the inflation update factor, see §(n)(2), page 8 of the Methods and Standards for Establishing Payment Rates—Inpatient Services, of this state plan.
(18) Medicaid inpatient utilization rate is the rate defined in §1923(b)(2) of the Social Security Act.
(19) Payments received from uninsured patients are those payments received from or on behalf of uninsured patients as defined in (b)(9).
(20) Charity charges are the total amount of hospital charges for inpatient and outpatient services attributed to charity care in a cost reporting period. These charges do not include bad debt charges, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan); that is, reductions or discounts in charges given to other third party payers such as, but not limited to, health maintenance organizations, Medicare, or Blue Cross.
(21) Allowable cost is defined by the state using the same methods and procedures that are reflected in both the inpatient and outpatient sections of the currently approved state plan.
(22) Available fund for state mental and chest hospitals is the sum of 100 percent of their adjusted hospital specific limits.
(23) Available fund for the remaining hospitals is the total federal fiscal year cap (state disproportionate share hospital allotment) minus the available fund for state teaching hospitals and minus the available fund for state mental and chest hospitals.
(c) The single state agency identifies the qualifying Medicaid disproportionate share

Reimbursement for the remaining hospitals is determined monthly as follows:

(1) The single state agency determines the average monthly number of weighted Medicaid inpatient days and weighted low-income days of each qualifying hospital.

(2) A qualifying hospital receives a monthly disproportionate share payment based on the following formula:

$$\left(\frac{1}{2} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Title XIX Days} * \text{Weight}}{\text{Total Avg. Mo. Weighted Medicaid Days}}\right) + \left(\frac{1}{2} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Low Income Days} * \text{Weight}}{\text{Total Avg. Weighted Low Income Days}}\right)$$

(f) The specific weights for certain hospital districts and children's hospitals are as follows:

(1) Children's hospitals are weighted at 1.25.

(2) MSAs with populations greater than or equal to 121,000 and less than 300,000 are weighted at 2.75.

(3) MSAs with populations greater than or equal to 300,000 and less than 1,000,000 are weighted at 3.0.

(4) MSAs with populations greater than or equal to 1,000,000 and less than 3,000,000 are weighted at 3.25.

(5) MSAs with populations greater than or equal to 3,000,000 are weighted at 3.75.

All MSA population data are from the most recent United States decennial census.

For State Fiscal Year 2004 (September 1, 2003, through August 31, 2004) and State Fiscal Year 2005 (September 1, 2004 through August 31, 2005), the monthly disproportionate share payment is subject to a conversion factor that is applied as follows:

(i) a conversion factor of 1.0875 is applied to payments made to hospital districts located in MSAs with populations greater than 3 million.

(ii) a conversion factor of 1.02 is applied to payments made to hospital districts located in MSAs with populations between 1 and 3 million.

(iii) a conversion factor of .974 is applied to payments made to children's hospitals

(iv) a conversion factor of .94 is applied to payments made to private, urban, general hospitals located in MSAs.

(v) a conversion factor of 1.0 is applied to payments made to all other hospitals.

SUPERSEDES: TN 02-13

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the fiscal year ending in the previous calendar year. The state or its designee uses the latest available Medicaid cost report in the absence of the Medicaid cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part I, Column 25, and total charges from Worksheet C, Part I, Column 6. The ratio is the total cost divided by the total gross patient charges.

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the fiscal year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges from reporting hospitals are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine the cost.

(h) The state or its designee trends each hospital's "hospital specific limit" calculated from its historical base period cost report from (g) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (b)(17), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit. **For purposes of calculating supplement payments as defined by Attachment 4.19-A, the hospital specific limit will be adjusted for current year supplemental payments to ensure that during the current state fiscal year a hospital does not receive more in total Medicaid payments than its cost of providing services to Medicaid patients and patients with no health insurance.**

(i) The state or its designee compares the projected payment for each disproportionate share hospital, as determined by (e) or (f), with its adjusted hospital payment limit, as determined by (g) and (h). If the hospital's projected payment is greater than its adjusted hospital specific limit, the state or its designee reduces the hospital's payment to its adjusted hospital specific limit.

(j) If there are disproportionate share hospital funds left in the available fund for the remaining hospitals, because some hospitals have had their disproportionate share hospital payments reduced to their adjusted hospital specific limits, the state distributes the excess funds according to the provisions of this section. For hospitals whose projected disproportionate share hospital payments are less than their adjusted hospital specific limits, the state or its designee does the following:

(1) calculate the difference between its adjusted hospital specific limit and its projected disproportionate share payment;
(2) add all of the differences from (j)(1);
(3) calculate a ratio for each hospital by dividing the difference from (j)(1) by the sum for (j)(2); and
(4) multiply the ratio from (j)(3) by the remaining available fund.

$$\text{Remaining Available} * \frac{\text{Hospital's Adjusted Limit} - \text{Hospital's Projected Fund Disproportionate Share Payment}}{\text{Total}}$$

patients. Uninsured patients are patients who have no health insurance or other source of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment.

(4) Hospital specific limit is the sum of the following two measurements: (a) Medicaid shortfall; and (b) cost of services to uninsured patients.

(5) Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan.

(6) Cost-to-charge ratio (inpatient and outpatient) is the hospital's overall cost-to-charge ratio, as determined from its Medicaid cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicaid cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.

(7) Adjusted hospital specific limit is a hospital specific limit trended forward to account for the inflation update factor since the base year.

(8) Inflation update factor is a general increase in prices as determined by the state. For additional information concerning the inflation update factor, see §(n)(2), page 8 of the Methods and Standards for Establishing Payment Rates—Inpatient Services, of this state plan.

(9) Medicaid inpatient utilization rate is the rate defined in §1923(b)(2) of the Social Security Act.

(10) Payments received from uninsured patients are those payments received from or on behalf of uninsured patients defined in (d)(3).

(11) Charity charges are the total amount of hospital charges for inpatient and outpatient services attributed to charity care in a cost reporting period.

(12) Allowable cost is defined by the state using the same methods and procedures that are reflected in both the inpatient and outpatient sections of the currently approved state plan.

(13) Available fund for state teaching hospitals is the total amount of funds that may be reimbursed to the state teaching hospitals as determined below.

(e) The single state agency reimburses state-owned teaching hospitals on a monthly basis from the available fund for state teaching hospitals. Monthly payments equal one-twelfth of annual payments unless it is necessary to adjust the amount because payments are not made for a full 12-month period, to comply with the annual state disproportionate share hospital allotment, or to comply with other state or federal disproportionate share hospital program requirements.

SUPERSEDES TN 01-10

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Prior to the start of the next federal fiscal year, the single state agency determines the size of the fund to reimburse state-owned teaching hospitals for the next federal fiscal year. The available fund to reimburse the state teaching hospitals equals the total of their disproportionate share hospital payments as determined in the following manner: a state-owned teaching hospital that meets the requirements for Medicaid disproportionate share hospital status receives annually 100 percent of its adjusted hospital specific limit.

(f) The state or its designee determines the hospital specific limit for each disproportionate share hospital. This limit is the sum of a hospital's Medicaid shortfall, as defined in (d)(5), and its costs of services to uninsured patients as defined in (d)(3), multiplied by the appropriate inflation update factor, as provided for in (g).

(1) The Medicaid shortfall includes total Medicaid billed charges and any Medicaid payments made for the corresponding inpatient and outpatient services delivered to Texas Medicaid clients, as determined from the hospital's fiscal year claims data, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, patients whose spell of illness claims were exhausted, or payments were denied due to late filing. (See definition of "Medicaid shortfall.")

The total Medicaid billed charges for each hospital are converted to cost, utilizing a calculated cost to charge ratio (inpatient and outpatient). The state or its designee determines that ratio by using the hospital's Medicaid cost report that was submitted for the fiscal year ending in the previous calendar year. The state or its designee uses the latest available Medicaid cost report in the absence of the Medicaid cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part I, Column 25 and total charges from Worksheet C, Part I, Column 6. The ratio is the total cost divided by the total gross patient charges.

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine

the cost.

After the state or its designee determines each disproportionate share hospital's cost of services to patients who have no health insurance or source of third party payments for services provided during the year, the state subtracts from each hospital's cost of services the amount of payments made by or on behalf of those patients who have no health insurance or source of third party payments for services provided during the year.

(g) The state or its designee trends each hospitals "hospital specific limit" calculated from its historical base period cost report from (f) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (d)(8), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit. **For purposes of calculating supplement payments as defined by Attachment 4.19-A, the hospital specific limit will be adjusted for current year supplemental payments to ensure that during current state fiscal year a hospital does not receive more in total Medicaid payments than their cost of providing services to Medicaid patients and patients with no health insurance.**